

Issues and Needs in the Provision of Substance Abuse Services to Adolescents in the State of Arizona

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Executive Summary

The Center for Applied Behavioral Health Policy, in concert with the Division of Behavioral Health Services, Arizona Department of Health Services, conducted 51 focus groups in all areas of the state to better understand the substance abuse service needs of adolescents and their families. Families, young adults, adolescents, and service providers participated in the groups.

Four major themes were explored:

- What forms of treatment models are currently being utilized and what forms of treatment models would clinicians like to learn about? What are the families' views of what is currently being practiced?
- How are treatment plans being developed and implemented? Specifically, are Child and Family Teams being used effectively?
- What resources are available to the providers and the adolescents and their families?
- Finally, what would the optimal treatment system look like?

Key findings included:

Treatment Approaches

- A wide variety of treatment approaches are used within the state.
- Clinical staff and supervisors questioned the ability to effectively measure implementation fidelity of the various treatment approaches.
- Some clinicians question the evidence base of some of the treatment approaches.
- The clinicians expressed a desire for the Department of Health Services to take a leading role in training staff in new evidence-based practices.

Treatment Planning and Coordination

- Use of Child and Family Teams is widespread, and most agree they are effective when properly implemented.
- A major concern is that the teams are less effective when one or more segments of the system do not participate or are not included in the team.
- Families are supportive of the Child and Family Team concept, although in some cases they do not fully understand it.

Infrastructure

- High caseloads and extensive paperwork are the most common issues facing the professional staff.
- Adolescents and their families see the need for more resources, including increased treatment options and alternative activities for the youth.
- Many participants agreed that prevention needs to be an integral part of the behavioral health process.

The Optimal System

- All segments agreed that more resources are needed to address substance abuse in the community, and all understood that additional funding is crucial.
- Among professional staff, smaller caseloads and reduced paperwork are keys to an improved system.

Based on the review of the data, the following recommendations are made:

- The Department of Health Services should take the lead in identifying appropriate evidence-based interventions, and ensuring that clinical staff throughout the state receive comprehensive training for that intervention.
- The Department of Health Services should work with the providers to develop approaches to assess treatment fidelity.
- The Department of Health Services should work with providers and participating families to develop meaningful outcome indicators.
- The Department of Health Services should work with other state agencies to ensure that all appropriate agencies are involved in the Child and Family Teams.
- The Department of Health Services should ensure that all consumers are educated on the Child and Family Team process, and that the language used to describe the process is understandable to all participants.

Introduction

How serious is adolescent substance abuse in Arizona? The Substance Abuse and Mental Health Services Administration's 2004-05 National Survey on Drug Use and Health estimates that 92,000 Arizona youth age 12-17 had consumed alcohol in the 30 days prior to the survey.¹ Of those, 59,000 had engaged in binge drinking and 57,000 had used illicit drugs in the last 30 days.

Assuming that these data are indicators of the need for treatment, adolescent substance abuse treatment should be a high priority for Arizona. Yet in 2006, only 3,809 of the total 60,105 persons admitted to the ADHS behavioral health service system for substance abuse treatment were adolescents.² This number likely underestimates the total number treated as there are many who may have sought treatment through private resources. Still, there is a significant gap between the services provided and the potential need. SAMHSA estimates that over 35,000 adolescents who needed treatment for alcohol abuse or dependence (based on a DSM diagnosis for abuse or addiction) went untreated in Arizona.³

At the same time, it is clear that Arizona youth understand the need for treatment. The following quotes from some of the adolescents participating in a series of focus groups conducted across Arizona asking what motivates them into treatment illustrate the value they place on treatment.

Knowing there is someone willing to listen and hear how they feel.

My life was falling apart—trustworthiness was lost.

Seeing parents using drugs at home and not wanting to be like them.

Gang affiliations—I do not want to be like them.

¹ Substance Abuse and Mental Health Services Administration. (2006). *Results from the 2005 National Survey on Drug Use and Health: National Findings* (Office of Applied Studies, NSDUH Series H-30, DHHS Publication No. SMA 06-4194). Rockville, MD.

² Arizona Department of Health Services, Division of Behavioral Health Services (2006). Annual Report on Substance Abuse Treatment Programs. Phoenix, AZ.

³ Substance Abuse and Mental Health Services Administration. (2006). *Results from the 2005 National Survey on Drug Use and Health: National Findings* (Office of Applied Studies, NSDUH Series H-30, DHHS Publication No. SMA 06-4194). Rockville, MD.

Seeing the effects of drugs on people's lives.

Realizing you aren't proud of the way you behave while you are on drugs or alcohol.

Drugs and alcohol created behavior that was not who I am, I was a different person.

This only highlights the need for access to efficient, quality treatment services throughout Arizona. As a first step in determining how best to address this need, the Division of Behavioral Health Services, Arizona Department of Health Services, and the Center for Applied Behavioral Health Policy at Arizona State University conducted a series of 57 focus groups held in 11 different communities from July 2006 through mid-October 2006.

Nearly 400 individuals, including parents, adolescents, young adults, and professional staff participated. Group participants were recruited by the Regional Behavioral Health Authority staff, who also arranged for the location of each group.

The Center for Applied Behavioral Health Policy conducted the groups for the program directors, clinical supervisors, and the clinical staff using a structured question format. Staff from the Division of Behavioral Health, Department of Health Services conducted the groups with the families, young adults and adolescents. CABHP compiled the data gathered from the program directors, clinical supervisors, and the clinical staff into summaries that are the basis of this report. DBHS staff compiled the data from the consumer groups and provided it to CABHP for inclusion into the report.

The focus groups were undertaken to better understand the service needs of adolescents from the perspective of the clinicians delivering the services and the adolescents and their families who receive the services. Four major themes were explored:

- What forms of treatment models are currently being utilized and what forms of treatment models would clinicians like to learn about? What are the families' views of what is currently being practiced?
- How are treatment plans being developed and implemented? Specifically, are Child and Family Teams being used effectively?
- What resources are available to the providers and the adolescents and their families?
- Finally, what would the optimal treatment system look like?

A review of some of the key findings is presented below. In the sections following, data from the various focus groups will be presented for each Regional Behavioral Health Authority service area. These will be followed by an overview section, including some recommendations for improvement.

Finally two tables are included at the end of the report. The first table is a compilation of some of the comments the professionals made when asked what they would say to the Governor regarding adolescent substance abuse treatment. The second is a “What Works” table that highlights what the professionals see as working in adolescent treatment, what isn’t working, and what gets in the way of change.

Key Findings

Treatment Approaches

- A wide variety of treatment approaches are used within the state.
- Clinical staff and supervisors questioned the ability to effectively measure implementation fidelity of the various treatment approaches.
- Some clinicians question the evidence base of some of the treatment approaches.
- The clinicians expressed a desire for the Department of Health Services to take a leading role in training staff in new evidence-based practices.

Treatment Planning and Coordination

- Use of Child and Family Teams is widespread, and most agree that they are effective when properly implemented.
- A major concern is that the teams are less effective when one or more segments of the system do not participate or are not included in the team.
- Families are supportive of the team concept, although some clinicians felt that some families lack a clear understanding of the Child and Family Team concept.

Infrastructure

- High caseloads and paperwork requirements are common issues brought up by the professional staff as impediments to good service.
- Adolescents and their families see the need for additional treatment options and activities for the youth that promote drug-free lifestyles.
- There was consensus among the focus group participants that prevention needs to be an integral part of the behavioral health process.

The Optimal System

- More resources are needed to address adolescent substance abuse in the community, and all understood that additional funding is the key.
- Smaller caseloads and reduced paperwork are keys to an improved system.

**Northern Arizona Regional Behavioral Health Authority
 Apache, Navajo, Coconino, Mohave, and Yavapai Counties**

Table 1: NARBHA Focus Groups

| Location | Type of Group | Number of Participants |
|-----------------|------------------------------|------------------------|
| Flagstaff | Families | 12 |
| | Adolescents | 5 |
| | Clinical Staff and Directors | 7 |
| Kingman | Families | 7 |
| | Adolescents | 6 |
| | Clinical Staff and Directors | 9 |
| Prescott Valley | Families | 2 |
| | Adolescents | 5 |
| | Clinical Staff and Directors | 4 |

Table 2: NARBHA Indicators⁴

| NARBHA Summary Data | Total Population Youth 14-17 | 30-days Alcohol Use | 30-days Marijuana Use | Binge Drinking | Depressive Symptoms | Early Initiation of Anti-Social Behavior | Total Number of Children Served By RBHA |
|---------------------------|------------------------------|---------------------|-----------------------|----------------|---------------------|--|---|
| Number of Youth | 43611 | 18916 | 8868 | 11796 | 23041 | 19461 | 3822 |
| Percentage of Youth 14-17 | | 43% | 20% | 27% | 53% | 45% | 9% |

Key Findings

- **The clinicians stated they used the Child and Family Team model, but families did not use language indicative of the Child and Family Teams**
- **Clinicians see the need for increased services, especially for non-Title XIX youth and those not involved with the judicial system**
- **Both clinicians and adolescents and their families noted a need for increased family involvement**
- **Families also noted a need for expanded alternative activities for the youth**

⁴ Data from the Arizona Youth Survey conducted by the Arizona Criminal Justice Commission. Data in the table are derived from the percentage of 10th grade respondents applied to the total population of youth age 14 to 17.

Treatment Approaches

Clinical Supervisors and Staff

The three clinicians/directors groups reported that they use the Matrix model, two of three note using 12-Step and the Hazelden model, and two of three noted that they used Motivational Interviewing as well as elements of Cognitive Behavioral therapy.

In one area, clinicians noted that the Youth Enjoying Sobriety (Y.E.S) program was effective.

Clinicians in one region noted that they had heard about the 7 Challenges curriculum but felt they could not pursue training as they were not likely to commit exclusively to that model. The other two sites also discussed that while they knew about Motivational Interviewing and the Matrix model, they would like more training in these methods. One site noted that they wanted to learn more about “Boot Camp for Parents,” a three- day parenting program. Another site noted that they wanted more training for the community and the staff.

Families and Adolescents

None of the family, adolescent or young adult groups reported the use of any specific therapeutic model in treatment. What they did describe is the effective use of a structured, respectful therapeutic environment. All the family groups noted that they would like to see staff increase methods for effectively involving families in treatment. All the family, adolescent and young adult groups noted that treatment could be enhanced by ensuring increased supports available for recreation and educational opportunities. Families in this area further noted that treatment is more effective when the probation system is actively involved. This involvement ensures accountability.

Q: What treatment best worked for you?

Follow-up by personnel— someone who cares about what’s happening when I get out of the program.

The habit of going to meetings and learning how to get support from people who are going through or have been through the same thing you are going through

Adolescent Group

Treatment Planning and Coordination

Clinical Supervisors and Staff

All three clinicians/directors groups reported that they utilize the Child and Family Teams and that the CFTs functioned well and improved service delivery. Staff noted that the differences in services provided by using this approach include: the CFT increases accountability and cross system coordination, identifies the families' needs and gets the families involved.

The CFT really gets the family involved—the children are tracked through the CFT and it increases accountability.

Clinical Supervisors and Staff Group

Families and Adolescents

While the clinicians spoke extensively about the value of the Child and Family Teams, the language of CFT was not used or described by either the families or adolescents. While it is likely that many of the families do participate in Child and Family Teams, they do not necessarily use the language to describe the experience in the same manner as the professionals. The families did talk about the increased accountability and structure the programs provided. Goal setting around recovery was also seen as a positive sign.

Infrastructure

Clinical Supervisors and Staff

All three clinicians and directors groups noted that there is a need to define and expand inpatient and outpatient services. Specifically, they noted the need for effective outpatient substance abuse services for adolescents and young adults who are non-Title XIX as well as services for youth who are not in the justice system. All three groups also agreed that there is a need for increased family involvement. All of the clinicians groups also noted the need for ensuring that if the family of the identified youth is abusing substances, there need to be services available for the family.

Out of 130 children, only 3 did not have substance abuse problems in their family—need to address substance abuse as a family, generational issue.

Clinical Supervisors and Staff Group

All three groups of clinicians and directors also reported that barriers to services include the need for safe transitional housing, transportation, and more clinic locations available in the rural areas. While funding is a challenge to ensure a strong infrastructure, a more serious concern reported by all groups was the availability of a highly qualified professional workforce to deliver services. One area reported that lowering caseloads would be an infrastructure improvement.

Families and Adolescents

All family and adolescent/young adult groups also noted the need for increased system support in the broader community resources for alternative healthy lifestyle activities as well as educational opportunities. Included in this were comments about increased community sports opportunity, having a community center to go to that was not linked to school performance, and more youth/adult events. Interestingly, all three families groups agreed that there is a need for increased family involvement. Several youth and parents mentioned that regular probation was not working in combating drug use, and that the police are not supportive of the families.

Sports programs that are available to everyone.

Something and some place to participate with no grade requirement, no costs and away from school.

Adolescent Group

The Optimal System

Clinical Supervisors and Staff

All three groups of clinicians and directors noted that the optimal treatment system would include increased access to transportation, secure transitional housing and a multi-generational/family treatment with a strong family accountability system. Two areas noted that there needs to be more creative programming with a focus on the additional supports that assist in “healthy living/sober living.” One area further noted that the ideal system includes staff training on substance abuse and human development issues. Specifically, this group related the need for staff to

Create avenues to ensure families are in treatment –shift the avenues for determining the identified patient, the family needs to be defined as the patient.

Clinical Supervisors and Staff Group

be “more aware of human behavior and child development and how to identify the underlying issues behind substance abuse.”

Not surprisingly, all three areas reported that insufficient funding has been the block to creating the optimal treatment system. However, they noted that it would be helpful for the system to expand the conceptual framework to ensure a multigenerational approach to treatment. They also advocated an increase in the variety of service available, i.e. “comprehensive wrap around services as well as step down services.” One area also noted that ideal system would address the confusing transitions for 17-18 year olds.

Families and Adolescents

Families reported that they would like to see more follow-up services and creative service delivery options made available to youth and families. One family group described a desire to see the public school, law enforcement and justice systems “learn to collaborate with families to address the issue of substance abuse among the youth.”

Cenpatico Yuma and La Paz Counties

Table 3: Cenpatico Focus Group

| Location | Type of Group | Number of Participants |
|----------|---------------------------|------------------------|
| Yuma | Families | 6 |
| | Spanish Speaking Families | 11 |
| | Adolescents | 5 |
| | Clinical Staff | 13 |
| | Clinical Directors | 9 |

Table 4: Cenpatico Indicators⁵

| CENPATICO Summary Data | Total Population Youth 14-17 | 30-days Alcohol Use | 30-days Marijuana Use | Binge Drinking | Depressive Symptoms | Early Initiation of Anti-Social Behavior | Total Number of Children Served By RBHA |
|---------------------------|------------------------------|---------------------|-----------------------|----------------|---------------------|--|---|
| Number of Youth | 12399 | 4081 | 1847 | 2808 | 7283 | 4359 | 1387 |
| Percentage of Youth 14-17 | | 33% | 15% | 23% | 59% | 35% | 11% |

Key Findings

- **Clinicians stated that the Child and Family Teams empowered the children and their families**
- **Families perceived that lack of cooperation between state agencies hindered treatment**
- **Clinical staff highlighted the problems of high caseloads and extensive paperwork**
- **Families and professionals all agreed that the system needs more resources in order to improve**

⁵ Data from the Arizona Youth Survey conducted by the Arizona Criminal Justice Commission. Data in the table are derived from the percentage of 10th grade respondents applied to the total population of youth age 14 to 17.

Treatment Approaches

Clinical Supervisors and Staff

For the most part, there was little discussion regarding specific treatment approaches within the groups. The clinical line staff mentioned several therapeutic approaches they were using and felt were effective. Three individuals mentioned Cognitive Behavioral techniques, another three called out Motivational Interviewing, while the Stages of Change model and Dialectical Behavioral therapy were each mentioned once. The only specific treatment approach mentioned by the program directors and clinical supervisors group was the Matrix model. 12-Step was also mentioned once.

A number of the professionals questioned the premise of evidence-based treatment practices. For example, one professional in the clinical staff group questioned the validity of the practices, and was concerned that not enough attention is paid to the variance in populations when particular approaches are mandated. Another wanted to see the evidence and not just be told that it is a best practice. Several also stated that insufficient training is provided on best practices, and that it is too expensive when offered.

Finally, two individuals in the clinical staff group expressed a desire to have more standardization of treatment protocols across the state. Two individuals in the management group expressed similar concerns. One questioned the quality of the research; another felt that calling it “evidence-based practice” is just the same old approach with a new name.

Finally, when the professional staff was asked about what additional training they would like to receive, no specific treatment models were mentioned. One individual mentioned wanting training on best practice protocols for specific problems, and another wanted training relevant to their region.

Families and Adolescents

One person in the family group mentioned Drug Court. They also talked about counseling, anger management, and family counseling. The Spanish-language family group mentioned good counseling, movement of children

We need more frequent and consistent counseling for our children.

We need more behavioral health counseling services for our youth.

Family Group

from detention immediately into treatment, and consistent counseling. The adolescent group had only one mention—counseling two times a week.

Treatment Planning and Coordination

Clinical Supervisors and Staff

This is an area where there was significant discussion, both positive and negative. First, virtually all of the professionals felt that the Child and Family Team process was an effective tool for treatment planning and coordination.

At least eight of the stakeholders spoke of the value of having parents actively involved in the process. Particularly, they mentioned accountability on the part of the parents, empowerment, and eliminating the isolation of the child from their parents in the treatment process. One stakeholder also mentioned the value of the process to the children. Having them involved helps them feel a sense of control.

[Child and Family Team] empowers the family. It teaches them how to drive the bus.

[Child and Family Teams are] good for the children. They feel helpless and they have no control but having them participate in the meeting is very important to them.

Clinical Staff Group

The group also felt that the Child and Family Team made coordination more efficient. There was mention of eliminating overlap—children having multiple therapists across several agencies—and getting everyone on the same page.

Families and Adolescents

While they did not discuss treatment planning and coordination to a great degree, the parents did make some observations. These included a comment that monthly meetings (presumably Child and Family Team meetings) were not frequent enough. Another parent observed that there was a lack of cooperation from other state agencies—specifically Child Protective Services.

The adolescents in this GSA did not speak to the issue of treatment planning and coordination.

Infrastructure

Clinical Supervisors and Staff

There were a number of comments regarding infrastructure in this region. The first was the role of the clinical liaison. Most of those in attendance at the clinical staff meeting felt that the concept just was not working. Their issues ranged from having too high a caseload to being responsible for every aspect of the adolescent's treatment—from case manager to therapist.

The role of the clinical liaison is not working: the demands of the role, the caseloads are too high and you are expected to know all about the children.

We can't be a team leader, a therapist and a clinical liaison and supervise cases and function well.

Clinical Staff Group

Two of the members of the clinical group said they had 400-plus children on their caseload. Part of that was attributed to lack of qualified clinicians in the area. Another manager felt that part of the problem was a lack of Spanish-speaking clinicians. Those who spoke Spanish had very large caseloads. Finally, one person felt that licensure was an impediment to getting qualified persons.

Paperwork was seen as the next most vexing issue. Again, almost all of the

clinical staff and clinical directors felt that the paperwork was overwhelming. When asked about the time spent on paperwork, the clinical supervisors group said anywhere from 25 to 70 percent of line staff time was spent on paperwork, time they cannot bill. The groups were especially critical of the assessment tool, stating that it was overly long and took so much time that some families would not finish it—they just quit. Several stakeholders also felt that much of the paperwork is driven by a fear of litigation.

Some time ago, it changed from a treatment document to a legal document. Everybody looks at our paperwork as a legal document and it's no longer our tool. How to change it, I do not know.

Clinical Supervisors Group

Families and Adolescents

The comments by the parents generally focused on lack of sufficient resources (not enough counselors or psychiatrists) and the time it took to get to see some

We feel our children need employment in the community and summer programs.

Spanish Speaking Family Group

providers. They also commented on the lack of services, including residential treatment facilities, substance abuse support groups, a lack of transportation, and inadequate follow-up services following residential treatment. Two individuals mentioned that calls to the 1-800 number at the RBHA were not answered. However, the comment made most often concerned the lack of alternative activities for the children. These included comments about sports, movies, dances, amusement parks, etc. and were made by both the parents and the children.

Finally, many of the respondents, both professional and consumer, highlighted the need for more prevention. This included prevention in the schools and in the community.

The Optimal System

Clinical Supervisors and Staff

There were numerous comments made on what an optimal system might look like. The previous section alluded to the need for more residential treatment, as well as alternative activities for the children where they can enjoy themselves in a drug-free environment. Prevention was also an element that was mentioned as needed in an ideal system. Finally, the groups mentioned the need to reduce paperwork, including streamlining the assessment tool. There was a clear desire to take the focus of the system back to the client and away from the paperwork.

The most often mentioned asset for an optimal system was additional resources. This included more money, more programming, more community services, etc. When responding to the question regarding what they would say to the Governor, “additional resources” was the most common remark.

Families and Adolescents

The parents said the same thing in their responses to the question of what did not work. The need for additional

We need to focus back on client care and not documentation of client care; the priority needs to be direct contact with the clients. Cut paperwork down to a minimum amount and make it more streamlined. Make it less!

Keep it simple and let us do our job.

Clinical Supervisors Group

We need a Behavioral Health Crisis Response Team for parents when a crisis with our youth occurs, otherwise we have to call the police who then charge us \$50 per day for their incarceration.

Spanish Speaking Family Group

resources, including residential treatment, was mentioned often. The one added comment made several times was the role of the justice system. Some felt that the police were more interested in dealing with immigration problems than the larger drug problems. Others felt that juvenile detention was the only option for children with substance abuse and mental health problems. There was no substantive information gained from the children about an optimal system.

Community Partnership of Southern Arizona Cochise, Graham, Greenlee, and Santa Cruz Counties

Table 5: CPSA 3 Focus Groups

| Location | Type of Group | Number of Participants |
|----------|---------------------------|------------------------|
| Douglas | Families | 6 |
| | Spanish Speaking Families | 8 |
| | Adolescents | 11 |
| | Clinical Staff | 7 |
| | Clinical Directors | 12 |
| Nogales | Spanish Speaking Families | 6 |

Table 6: CPSA 3 Indicators⁶

| CPSA 3 Summary Data | Total Population Youth 14-17 | 30-days Alcohol Use | 30-days Marijuana Use | Binge Drinking | Depressive Symptoms | Early Initiation of Anti-Social Behavior | Total Number of Children Served By RBHA |
|---------------------------|------------------------------|---------------------|-----------------------|----------------|---------------------|--|---|
| Number of Youth | 21341 | 9005 | 2887 | 5532 | 11344 | 9639 | 1730 |
| Percentage of Youth 14-17 | | 42% | 14% | 26% | 53% | 45% | 8% |

Key Findings

- **Clinicians emphasized the need for more training—both for themselves and non-clinical staff involved in the process**
- **Clinicians felt that the Child and Family Teams were a positive addition, making the families part of the solution**
- **Families were more critical of the planning process, highlighting the lack of information on the plan and lack of cooperation of some agencies**
- **Clinicians felt that there was a lack of appreciation by DHS regarding the border issues they faced**
- **Families expressed a desire for more respect from the system for themselves and their children**

⁶ Data from the Arizona Youth Survey conducted by the Arizona Criminal Justice Commission. Data in the table are derived from the percentage of 10th grade respondents applied to the total population of youth age 14 to 17.

Treatment Approaches

Clinical Supervisors and Staff

As observed in other groups, there was not a tremendous amount of discussion regarding specific treatment approaches. The professional staff mentioned a number of best practices. Several mentioned Drug Court. Motivational Interviewing was mentioned twice. Several staff, specifically in relation to Drug Court, mentioned the Seven Challenges program. Brief Strategic Family therapy was also mentioned.

Several statements were made regarding training. The first was an observation by one individual that more non-Drug Court related staff should receive training on the Seven Challenges program. The second was a comment that they needed more Motivational Interviewing training. One staff member felt that they needed a curriculum for the parents involved in Drug Court. Another wanted a curriculum that could be delivered by non-clinical staff so children mandated by Drug Court do not always have to go to a clinician.

Families and Adolescents

The treatment most mentioned by families was Drug Court. However, several mentioned residential rehab, and one talked about Intensive Outpatient treatment (IOP), although there was no definition of what they meant by IOP. Another parent talked about Life Skills training, and there was some mention of the usefulness of medication. One adolescent mentioned Drug Court.

Treatment Planning and Coordination

Clinical Supervisors and Staff

All of the clinical staff and clinical supervisors felt that the Child and Family Teams were beneficial. They felt they were more client centered, that parents became part of the solution, and that in Bisbee they got the teachers involved in the process. The supervisor group noted the increased partnerships across a variety of groups, including service clubs, state agencies, and the medical community.

[CFT's] are client centered—they are coming up with what they are going to do instead of being told what to do.

Clinical Staff Group

The supervisors group also noted that using the CFT process allowed the team to address some of the issues the parents had as well.

This group also highlighted the collaboration with the justice system through Drug Court. They indicated that they saw the presence of the judicial system as part of the process as ensuring parental compliance with the program. At the same time, they were somewhat critical of the role of the judges, feeling that they did not have sufficient training to make some of the decisions they made.

Drug Court works when it is consistently applied. When the client is part of planning it really works.

Clinical Staff Group

Families and Adolescents

The parents' comments tended to be more negative. In one of the Spanish-speaking groups, there were two comments regarding the lack of information on the contents of the treatment plan. Another parent felt that too little consideration was given to the fact that they had to work, and that meetings were

Would like sessions for multiple children in treatment with different therapist to be planned together on the same day at the same time.

We like the 'wrap-around' teams.

Spanish Speaking Family Group

scheduled at inconvenient times. There were also comments on a lack of coordination between probation officers and the behavioral health system. Finally, there were several families who brought up a lack of timeliness from the system.

Infrastructure

Clinical Supervisors and Staff

There were numerous comments about the infrastructure. The supervisory group highlighted the need for more groups for adolescents as well as a teen center. They felt that there should be a mentoring program for teens. They also highlighted the need for a peer support center. As mentioned above, they felt that the judges in the area needed a better understanding of the behavioral health system.

This group brought funding up as an issue as well. One participant felt that more funding should be directed toward out-of-school activities. Funding was also highlighted as a factor in recruitment, specifically the

low pay characterizing this field. They also thought that the rural nature of the service area was an issue in recruiting. Surprisingly, only one person made any comments regarding the paperwork.

They did mention border issues, from the perspective of the presence of drugs, the role the Border Patrol plays, and a lack of understanding in Phoenix and Tucson about the impact of the being a border community. One person also mentioned that they saw a difference in drug interdiction when the National Guard was moved from a drug reduction role to patrolling the border.

Families and Adolescents

The parents also highlighted several areas where they thought infrastructure was lacking. For example, one group stated a need for more socialization activities for the youth in the community. They also saw a need for more educational opportunities so the adolescents could get their GEDs. They felt there was a need for more counselors, and for more staff to manage Alternative Educational Programs, rather than forcing the children back into the mainstream schools where they were already unsuccessful. They indicated a need for support groups for siblings of drug abusing youth, and for additional counseling for the parents' issues.

We need support groups for siblings of youth who are using drugs in the home.

Families need to be empowered and supported by clinical staff.

The only resource we have as parents is "911" which takes our youth into the juvenile justice system.

Spanish Speaking Family Group

The also expressed a need for more support for the family, including help with supervising the youth when the parents are at work and in-home therapists to help the family work together.

Finally, woven throughout the comments from all groups, professional staff and families was the issue of prevention. A consistent theme was a need for prevention in the schools and in the community.

The Optimal System

Clinical Supervisors and Staff

For the stakeholders within this region, the first step toward an optimal system begins with the integration of treatment and prevention. It should

begin early and extend throughout the community. This theme cut across all groups that participated.

The ideal system would be one that has a continuum of care that involves all the agencies that touch the clients and their families' lives, including the medical health system, the behavioral health system, the justice system, the child welfare system, the education system, etc. The system needs to treat the whole family, not just the adolescent. In turn, the families and the children need to be more responsible and openly participate in the program.

Families and Adolescents

For the families, there is a need for more respect for both the families and the children. They would like help with parenting classes, and support on the weekend. The families also spoke about support for siblings and classes for the youth on understanding the connection between drugs and violence.

Do not disempower parents by telling children that their parents cannot make them do something they do not want to do.

Need something other than 911 on the weekend, which just takes them to Juvenile Justice.

Family Group

Finally, the ideal system would be one where there are sufficient resources for all the families in need, not just the ones involved in the judicial system.

Cenpatico Pinal and Gila Counties

Table 7: Cenpatico Focus Groups

| Location | Type of Group | Number of Participants |
|----------|---------------------------|------------------------|
| Douglas | Families | 6 |
| | Spanish Speaking Families | 8 |
| | Adolescents | 11 |
| | Clinical Staff | 7 |
| | Clinical Directors | 12 |
| Nogales | Spanish Speaking Families | 6 |

Table 8: Cenpatico Indicators⁷

| CENPATICO Summary Data | Total Population Youth 14-17 | 30-days Alcohol Use | 30-days Marijuana Use | Binge Drinking | Depressive Symptoms | Early Initiation of Anti-Social Behavior | Total Number of Children Served By RBHA |
|---------------------------|------------------------------|---------------------|-----------------------|----------------|---------------------|--|---|
| Number of Youth | 16315 | 6927 | 3191 | 4368 | 8384 | 7542 | 2212 |
| Percentage of Youth 14-17 | | 42% | 20% | 27% | 51% | 46% | 14% |

Key Findings

- **Clinicians voiced a desire for more hands-on training, especially with the Matrix model**
- **Families and adolescents felt that mentors with recovery experience were an important factor**
- **Clinical staff saw the Child and Family Team as an effective way to coordinate treatment planning, especially with juvenile justice**
- **Clinical staff and the families mentioned the need for a local detox center**
- **Transportation support was called out as a critical need**

⁷ Data from the Arizona Youth Survey conducted by the Arizona Criminal Justice Commission. Data in the table are derived from the percentage of 10th grade respondents applied to the total population of youth age 14 to 17.

Treatment Approaches

Clinical Supervisors and Staff

The groups from this region mentioned a number of treatment approaches. The supervisors groups mentioned the Hazelton model, which is used in a foster home treatment setting, the Drug Court program, the Matrix model, the “Spirit Within” program, and the Seven Challenges program. The line staff mentioned the Matrix model, which three of four participants used, Cognitive Restructuring, and the Seven Challenges program. One participant did comment that the Seven Challenges program was effective, but less so than previously because the current therapist did not connect with the children. Another participant felt that program effectiveness was enhanced due to the addition of court consequences as part of the program.

We need to broaden our knowledge on the case. We need to know not only the treatment as a therapist, but the case management issues, like: does this person have electricity?

Clinical Staff Group

From a training perspective, the professional staff wanted more training in all of the approaches mentioned. They felt that they needed more training on the Matrix model, with more detail on the delivery of the model, using more role playing to learn. The therapists wanted more training on case management, feeling that they needed to know more of what was going on in the children’ lives.

Families and Adolescents

The parents did not indicate any particular program, but did highlight some approaches they felt were effective. Mentors were mentioned several times. Persons from both parent groups mentioned mentors with recovery experience. They also felt that staff with recovery experience were more effective. Other ideas included treatment for incarcerated youth, halfway centers, and support groups that allow voice. The adolescent group also emphasized working with persons with recovery experience—including peers and role models. They also felt that unconditional support from adults in the program was very important.

Treatment Planning and Coordination

Clinical Supervisors and Staff

CFT—Involves the parent, family, court representative and the child. It's a good collaboration with the court system and the clinical side. We can evaluate the children before we just decide to lock them up.

Clinical Staff Group

All of the staff in this group said they worked with Child and Family Teams, and for the most part felt the teams are an effective way to coordinate activities, especially with the justice system. They indicated that the teams improved the manner in which juvenile probation treated the clients.

On the other hand, one individual

highlighted the difficulty of working with dysfunctional families, stating that they do not know how to behave in a healthy environment. The clinical staff group also spoke of a local effort where they work with the liquor board to determine if local outlets are selling to underage children.

Strongly discouraged from using inpatient services and it's a huge barrier ...sometimes it is the only option for some children in order for them to be in a safe place.

Clinical Supervisors

There was an indication of some friction between treatment providers and CPS. A statement was made that while CPS administrative staff were cooperative, the CPS line staff interacted in an adversarial manner—that they have a hidden agenda. One person also commented that the CPS workers were overworked, and as a consequence were not able to prepare for the family team meetings.

There were also some comments about lack of coordination between agencies, and the added workload that comes from the lack of coordination. Finally, there were two comments regarding Cenpatico's reluctance to approve residential treatment. The clinical supervisor group felt that it was a safety issue.

Families and Adolescents

Neither the family groups nor the adolescent group addressed treatment planning and coordination.

Infrastructure

Clinical Supervisors and Staff

A number of comments were made concerning infrastructure. One person mentioned that there was a new Level 1 residential treatment facility in the area, and that there were also Level 2 residential programs. However, it was also stated that there was no detox facility in the area.

Several of the staff spoke of a need for transportation, especially given the large rural area they were working in. In one case, a clinician mentioned that there was an agency van, but it could only be used to transport SMI clients. Another mentioned that the taxi company would transport for medical treatment.

In a related issue, one staff mentioned that the parents get upset because, even though they live in Phoenix, their children are busted in Pinal County and the parents have to take them there for treatment. Another supervisor mentioned that they have to treat the children where they live, so they have to hire staff in Tucson and Phoenix to provide services virtually statewide.

Several staff mentioned the bureaucracy as a problem. These comments included concerns that clinicians spend more time doing paperwork than delivering service to concerns that people are leaving the field because of the excessive paperwork.

Caseloads were also cited as a problem. Several staff mentioned large (60 or more) caseloads and the difficulties that arise when a case manager or therapist leaves and that person's cases are distributed to the remaining workers. There was also some concern voiced that the workload, combined with the rural location and low pay, had an adverse impact on recruitment.

Other infrastructure issues voiced by the professional staff included the lack of safe housing for the young adults and lack of funding for kin care.

Caseworkers are inundated with so much paperwork and job duties. We can't get what we need from the case manager because they are so overwhelmed and then they can't get to the child.

Clinical Staff Group

Families and Adolescents

The parents also mentioned the need for a detox center, and the need for affordable housing. They also said that they need better AHCCCS coverage to help pay for medicine.

Finally, every group in this GSA also felt prevention needs to be broadened. Additionally, this group also mentioned the need for funding for aftercare.

The Optimal System

A number of ideas surfaced regarding the make-up of an optimal system. First, prevention needs to be integrated into the system at all levels. The families proposed that educators need to have better training in recognizing behavioral health problems. The ideal system would also include alternative activities for the children, including faith-based groups and culturally appropriate activities. The adolescents also included added peer support and the presence of their families in process.

All the groups in this region felt that any system needs to have transportation support for the clients, as well as housing and educational support for the young adults.

The optimal system would have smaller caseloads and less paperwork. There would be sufficient funding for staff and funding support for the clients.

The system would be driven by the Child and Family Team, and have a full continuum of care available to the families. It would be strength-based, culturally appropriate system that is inclusive of all the players in the system.

Finally, there would be sufficient facilities, including a detox center, available in the local area.

Community Partnership of Southern Arizona Pima County

Table 9: CPSA 5 Focus Groups

| Location | Type of Group | Number of Participants |
|----------|---------------------------|------------------------|
| Tucson | Families | 12 |
| | Spanish Speaking Families | 3 |
| | Young Adults | 10 |
| | Adolescents | 6 |
| | Clinical Staff | 9 |
| | Clinical Directors | 10 |

Table 10: CPSA 5 Indicators⁸

| NARBHA Summary Data | Total Population Youth 14-17 | 30-days Alcohol Use | 30-Days Marijuana Use | Binge Drinking | Depressive Symptoms | Early Initiation of Anti-Social Behavior | Total Number of Children Served By RBHA |
|---------------------------|------------------------------|---------------------|-----------------------|----------------|---------------------|--|---|
| Number of Youth | 51156 | 19439 | 8390 | 11510 | 24811 | 20923 | 7810 |
| Percentage of Youth 14-17 | | 38% | 16% | 23% | 49% | 41% | 15% |

Key Findings

- **Clinical supervisory staff expressed a concern about the ability to assess implementation fidelity**
- **Adolescents and young adults express a need for more mentoring, especially from mentors with recovery experience**
- **Clinical staff valued the Child and Family Team process, although they admitted that it did not work if everybody did not cooperate**
- **Families highlighted the need for effective communication with the families in the system and the community at large**
- **Clinical staff observed that homeless youth have difficulty getting into the system, and that they do not do a good job with children outside the norm—specifically with the LGBT population**

⁸ Data from the Arizona Youth Survey conducted by the Arizona Criminal Justice Commission. Data in the table are derived from the percentage of 10th grade respondents applied to the total population of youth age 14 to 17.

Treatment Approaches

Clinical Supervisors and Staff

The groups in this region mentioned a variety of treatment approaches. The professional staff mentioned the Matrix model, brief therapy, Cognitive Behavioral therapy (mentioned most often), 12-Step, the Seven Challenges model and Motivational Interviewing. The Hazelton model was also mentioned, as were Functional Family therapy, Multisystemic therapy and Brief Strategic Family therapy. Drug Court was also mentioned as an effective approach, although the limited availability was an issue.

Need to provide more services to non-Title XIX children...and we need to figure out how to help undocumented children.

Clinical Supervisor Group

When talking about evidence-based practices, the supervisory group brought up the issue of fidelity to the model. They felt that the effort to measure fidelity was inadequate, and that more should be done.

Drug Court: intense supervision by the Juvenile Court, the child sees the judge every week, they know a surveillance office is going to come, they are going to drop, they know they are going to be in the program for a year.

Clinical Staff Group

This group did not specify any particular training, but did state that they would like to see more. They also felt that ADHS could provide more money for training as well. Finally, there was some discussion regarding the definition of evidence-based practices, and a desire for ADHS to provide more direction in regard to evidence-based practices.

We would like the same age mentors assigned from the beginning of our treatment program.

I would like to talk to somebody close to my age, like a mentor to help me with transition.

We need families to participate with young adults after rehab.

Young Adult Group

Families, Adolescents and Young Adults

The families highlighted a need for 12-Step groups for young people, peer and community mentoring with individuals with recovery experience, youth groups for older children (19 and over) that can share their experiences and age-appropriate support groups.

The young adult group also mentioned peer

support and mentoring, and felt that life skills training was useful, as did the adolescent group. The adolescents also felt that family support through improved communications and increased involvement in their lives was helpful.

Treatment Planning and Coordination

Clinical Supervisors and Staff

The professionals in this region emphasized the value of Child and Family Teams. They felt that the teams were mostly working well, and that they did add support not traditionally offered through the normal approach. They also felt that for the most part, the teams did increase collaboration across agencies, and were especially useful in coming to consensus when agency mandates conflict. They were also seen to be a way of ensuring that duplication of services is not occurring. The adolescent group felt that the Child and Family Teams gave them a voice in decision making as well.

Good venue of not allowing miscommunication—the child is present, the family is present and we aren't going to tell this child what they need. They have a part in the decision-making—everyone is involved in the process and there is consistency on a regular basis.

Clinical Staff Group

At the same time, the groups acknowledged that making CFTs work is not necessarily easy. They felt that at times, the therapist or the court does not agree with the CFT and goes in a different direction. They also felt that there are times when services are being duplicated because children are being referred both to the network and other agencies. This was seen as a problem mainly with probation. They felt that one solution to the problem was to have the probation officer be part of the CFT.

The supervisory group also commented on the many demands made of the families, cautioning that the system needs to be conscious of the upper limit on their time.

Families, Adolescents and Young Adults

The families made two points. First they felt that the system should communicate more with the parents. Second, they felt that the system should do a better job of letting the community know what services are available.

Infrastructure

Clinical Supervisors and Staff

One of the discussions in the two professional groups revolved around the access to services. They felt that there were numerous boundaries that needed to be addressed. They included transportation problems brought on by the large geographic area, much of it rural. They also observed that homeless youth have difficulty getting into the system, and that they do not do a good job with children outside the norm—specifically with the LGBT population. They also highlighted the time it can take to get services (up to six months) and the difficulty some have navigating the system. They mentioned that it was difficult to find placements for sex offenders and active substance users.

Need to provide more services to non-Title XIX children...and we need to figure out how to help undocumented children.

Clinical Supervisor Group

In a similar vein, they talked about needing to deliver services when it is convenient to the consumer, not the agency. They also mentioned that they need to make sure that all the areas in the county have access to services. The parents also mentioned these issues. The parents also talked about the difficulty associated with transitioning between networks, and problems with getting substance abuse treatment.

From a service delivery perspective, the professionals felt that more therapists were needed, especially Spanish speakers. There was mention of high staff turnover, both in the behavioral health system and at CPS. As is common with the other regions, excessive paperwork was also seen as a problem. They also highlighted heavy caseloads.

Families, Adolescents and Young Adults

The parents talked about the need to deliver services when and where it is convenient to the consumer, not the agency. The parents also talked about the difficulty associated with transitioning between networks, and problems with getting substance abuse treatment.

We need AA groups for young people.

Family Group

Finally, all the groups alluded to the need for prevention as an integral part of the system.

The Optimal System

This group gave the impression that the system is not necessarily broken, but could be made better with more resources and increased collaboration between agencies involved in the families' lives.

This region would first include prevention, beginning as early as the third grade, as a part of the system. This was mentioned by all of the groups interviewed. Family involvement and support is also a key element in the optimal system. The staff, parents, young adults and adolescents all see mentors as a part of the optimal system as well. This includes both peer mentors and older persons.

The supervisors group thinks a Web-based communication system among partners would be useful, especially in reducing paperwork—a goal of the line staff as well. More qualified staff would be an important element as well.

The ideal system would offer a range of services—not just behavioral health, but recreational activities, fitness centers and after-school programs that provide children opportunities to stay clean and sober. Transportation would be an important element, as well as increased access for all groups.

Finally, the group felt that more intensive services are needed, as well as in-home services that involve the whole family.

Value Options Maricopa County

Table 11: Value Options Focus Groups

| Location | Type of Group | Number of Participants |
|-------------|---------------------------|------------------------|
| Central | Families | 6 |
| | Spanish Speaking Families | 11 |
| | Young Adults | 8 |
| | Adolescents | 8 |
| | Clinical Staff | 7 |
| | Clinical Directors | 4 |
| West Valley | Families | 4 |
| | Young Adults | 7 |
| | Adolescents | 3 |
| | Clinical Staff | 25 |
| | Clinical Directors | 4 |

Table 12: Value Options Indicators⁹

| NARBHA Summary Data | Total Population Youth 14-17 | 30-days Alcohol Use | 30-days Marijuana Use | Binge Drinking | Depressive Symptoms | Early Initiation of Anti-Social Behavior | Total Number of Children Served By RBHA |
|---------------------------|------------------------------|---------------------|-----------------------|----------------|---------------------|--|---|
| Number of Youth | 206947 | 85883 | 32077 | 50702 | 100783 | 74087 | 19781 |
| Percentage of Youth 14-17 | | 42% | 16% | 25% | 49% | 36% | 10% |

Key Findings

- **Young adults and adolescents both mentioned the value of having mentors with recovery experience as part of the process**
- **Clinical staff were supportive of the Child and Family Team approach, but expressed concern over having to play multiple, sometimes conflicting roles**
- **Clinical staff also felt that families need to be better educated about their role on Child and Family Teams**
- **Clinical staff noted the lack of service in areas of the county, and the disparity between resources for adults and children**
- **Families talked of the need for age-appropriate treatment plans, and the need for a planned transition from adolescent services to adult services**

⁹ Data from the Arizona Youth Survey conducted by the Arizona Criminal Justice Commission. Data in the table are derived from the percentage of 10th grade respondents applied to the total population of youth age 14 to 17.

Treatment Approaches

Clinical Supervisors and Staff

The participants from this region mentioned a number of different treatment approaches currently in use. The professionals included Motivational Interviewing, Cognitive Behavioral therapy, Integrated Motivational Interviewing and Cognitive Behavioral therapy, the Seven Challenges program, Functional Family therapy, Solution Focused therapy, Narrative therapy and 12-Step. There was also some mention of Drug Court.

The professional groups felt that more training was needed, that the level of training among the staff was uneven. They felt that both in-house and outside training was useful, but that there were insufficient resources to get all that they needed.

Finally, there was one comment made regarding new social workers. The person felt that the schools tend to focus on office-based practice, not public sector behavioral health. They spend a lot of time retraining these graduates to operate in the public sector.

Families, Adolescents and Young Adults

Counselors should be more engaging with children when they are talking to them.

Adolescent Group

We need social events to create friendships with peers.

Young Adult Group

The families did not mention specific approaches, but did talk about increasing family involvement, life skills training and re-socialization. Young adults and adolescents both mentioned the role of peer mentors, and the value of having persons who have been through recovery as part of the process. The adolescents also spoke of receiving coping skills training.

Treatment Planning and Coordination

Clinical Supervisors and Staff

Almost all of the participants are involved in Child and Family Teams, and most felt they were effective. The professionals noted that when properly implemented, the teams got the parents involved and gave everyone in the family a voice in process. Professionals and families alike

noted that the teams increased interagency cooperation, with the families emphasizing the increased collaboration seen from the educational system.

There were some concerns noted about Child and Family Teams. One supervisor noted that some ethical issues arise when service providers play multiple roles within the system. Line staff noted that there are times when the therapist is not invited to the team meeting. They also noted that parents do not necessarily understand the process, and they need to be better informed of their role on the team.

CPS was a closed system and family members often had no idea what was going on in treatment. Families have input in the CFT process, the family is more aware and they have input on whether or not the treatment being provided is being helpful or not, more active in determining outcomes and additional service needs.

Clinical Supervisor Group

There were other issues discussed, including the need to increase interagency cooperation. The supervisors felt that agencies sometimes engage in power struggles and funding battles. There were some concerns about the interface with CPS and different approaches to what is best for the child and family. Finally, both line staff and clinical supervisors felt that the system needs a better assessment tool.

Families, Adolescents and Young Adults

The parents brought up several issues with the process. They observed that the process works best when not cut short. They think that the CFT should be part of the transition from child to adult services. Parents and young adults both talked of having age appropriate treatment plans.

Do not set us up to fail.

I want more involvement in the decision making and choosing of our consequences to rules that are broken and that will help with increasing accountability.

Young Adult Group

Infrastructure

Clinical Supervisors and Staff

There were a number of issues raised regarding infrastructure. Many of them mirror those of other regions. They include the paperwork mandated by the state and Value Options, transportation and high caseloads. They also brought up a few unique issues.

Maricopa County is one of the fastest growing counties in the nation, and the system can't keep up with the growth. There are some areas where there are no services for youth available—specifically West Valley, Litchfield, and Avondale. One of the groups raised the issue of co-occurring disorders and the fact that they are not addressed as frequently as they should be.

When they are ready for treatment, most times treatment is not ready for them.

Clinical Staff Group

One participant noted that one of the reasons for the high caseload is an inability to close cases when families refuse services. The group also talked about the disparity between youth and adult services. Adults have more access to residential treatment and aftercare. They also talked about the time it takes to get children into care.

Families, Adolescents and Young Adults

The consumer groups also had a variety of infrastructure issues. One concern was with the practice of taking children out of group homes when they break the rules. This includes taking children to shelters when they test dirty. They also felt that there need to be more activities for children that provide a safe, drug-free environment. The families also addressed co-occurring disorders and the lack of programs that deal with them.

Consumers also talked about age-appropriate and developmentally appropriate treatment plans, and the need for a better program for transition from youth to adult programs.

Finally, as with the other regions, the lack of an integrated prevention program is seen as a key shortfall in the system.

The Optimal System

Many of the ideas that arose in the other regions were raised in these groups. More resources are needed, transportation needs to be addressed, and the system needs more qualified licensed providers. This group also felt that that a better continuum of care needs to be provided.

As in other groups, these respondents felt that there needs to be a system that includes parent and adolescent peer mentors. They feel the ideal system includes social activities in a drug-free environment, and a system that addresses the intergenerational drug problem.

The parents raised two additional issues. First, families need to be better informed about the services available in the community for treatment, and wanted access to help 24-hours a day.

Finally, the system must include prevention—educating youth and parents as well as the community on what can be done regarding substance abuse.

Pasqua Yaqui Tribal Regional Behavioral Health Authority

Table 13: Pasqua Yaqui Focus Groups

| Location | Type of Group | Number of Participants |
|--------------------------|--------------------|------------------------|
| Pasqua Yaqui Reservation | Families | 6 |
| | Adolescents | 8 |
| | Clinical Staff | 10 |
| | Clinical Directors | 11 |

Key Findings

- **Clinical staff emphasized traditional approaches to treatment**
- **Clinical staff also used the Child and Family Team approach, and emphasized the need for continuation during the transition to adulthood**
- **Families were concerned about the lack of cooperation from probation and the educational system**
- **Unique to the Tribal RHBA were concerns about state mandates and how Tribal law impacted when children got into the system**
- **Families spoke of the need to integrate prevention and treatment—that they should be one thread**

Treatment Approaches

Clinical Supervisors and Staff

Pasqua Yaqui groups mentioned EMDR as an approach as well as many of the other techniques. They also highlighted traditional approaches—equine therapy and adventure tracking (SEWAMEECHA). They also mentioned they were trained in Reactive Attachment Disorder methods due to the large level of trauma on the reservation. They said they want to learn more about psychopharmacology, psychodrama, Gestalt techniques, and fathering skills training.

Families and Adolescents

The Pasqua Yaqui consumers identified working with therapists who have experienced recovery as an effective approach.

Treatment Planning and Coordination

Clinical Supervisors and Staff

Child and Family Team—it takes time to implement but it brings more people to the table. We call the crisis plan a ‘safety wellness plan’...it’s strength-based and a culturally appropriate process. They really like it and it’s a strong positive emphasis for the family and helpful for them.

Clinical Staff Group

The Pasqua Yaqui also use the Child and Family Team approach, saying that they used the approach before it was mandated by the state. In fact, they stated that they continue to use the teams for youth after they turn 18. They did have a number of problems with it, however. Most of those are

infrastructure issues that will be discussed in the following section.

They did mention that there were coordination issues between tribal behavioral health and the tribal justice department, mostly a lack of flow of information.

Families and Adolescents

Consumers felt the educational and probation systems were not working with behavioral health. They felt that probation was not providing any follow-up or support for the family, and was not communicating with them.

Infrastructure

Clinical Supervisors and Staff

The Pasqua Yaqui had a number of infrastructure issues surrounding the Child and Family Teams. They felt that the high caseload made it difficult to coordinate the team meetings. They were looking for a coordinator, but did not have one yet. They also said that space was an issue.

Like many groups, the Pasqua Yaqui group felt that the paperwork demands get in the way of treatment. They feel that they have to do everything that Value Options or CPSA do, but have far less staff. They also

It’s difficult for me as a Native American working for a Native American agency that the state mandates and dictates cultural competency. A recommendation is to have Native Americans on the board for all of it. There should be one to have a native voice at the state level.

Clinical Staff Group

spoke about the elimination of case managers and the impact it has had on their workload.

They mentioned a couple of unique issues as well. Court proceedings are confidential by Tribal law, so children are often identified too late in the process—they do not get services until they are adjudicated. They also talked about the fact that tribal members live in many areas of the state, which makes serving them a difficulty.

There were a number of comments regarding the interface between the state and the tribe. For example, they asked whether their therapists need to be licensed, since they are a sovereign nation. They also felt that it was unnecessary for the state to mandate cultural competency training in their own culture. They also wanted to integrate Native Americans into the network—including having more Native Americans on state boards to represent the tribes.

Families and Adolescents

The families and adolescents also had infrastructure concerns. They are concerned about counselors who are more committed to the clock than to the children. They felt there was not sufficient follow-up support to prevent crisis. They were also concerned about crisis support—the only option is calling the police.

Finally, the common thread is the lack of prevention services. Both the professional group and the consumers felt that prevention needs to be integrated into the network—they should not be considered as separate threads.

Gila River Tribal Regional Behavioral Health Authority

Table 14: Gila River Focus Groups

| Location | Type of Group | Number of Participants |
|------------------------|--------------------|------------------------|
| Gila River Reservation | Families | 7 |
| | Adolescents | 7 |
| | Clinical Staff | 14 |
| | Clinical Directors | 5 |

Key Findings

- **Clinical staff felt that the Child and Family Teams were useful, and helped develop relationships in a culturally relevant manner**
- **Clinical staff felt that the coordination between the three agencies providing services could improve**
- **Families voiced a desire for more communication, feeling that in some cases confidentiality made families feel cut off**
- **Families also felt that there need to be more recreational activities for the youth**

Treatment Approaches

Clinical Supervisors and Staff

The Gila River groups mentioned a number of approaches. They included the Matrix model, Cognitive Behavioral models, Drug/Teen Court and suicide prevention training. They also mentioned a number of traditional programs, including sweat lodge therapy, a fathering program, and others. The professionals felt that they would like additional training on the Matrix model and suicide prevention. There was one who felt that Cognitive Behavioral therapy was not effective with Native Americans, and that evidence-based practices are not effective with individuals with trauma—which is very prevalent on the reservation.

Help families understand the recovery jargon, i.e. clean and sober, co-dependency...

Family Group

Families and Adolescents

Gila River consumers highlighted Life Skills Training, anger management, equine therapy, self-esteem programs, and support for young mothers.

Treatment Planning and Coordination

Clinical Supervisors and Staff

Gila River uses the Child and Family Team model. They see the benefit of taking a team approach and tailoring services to the specific needs of the family. They also see the teams as building relationships in a culturally relevant manner. However, they see some shortcomings with the teams. They do not see CFTs as effective as they could be because of all the documentation required. The professional staff also emphasized the ability to access specialized resources, such as respite services, addiction specialists and psychologist support. They also felt that the fact that all the therapists are licensed is a benefit to the system.

The professional staff mentioned their concern with the service system infrastructure. Some programs are run by the tribe, some by the RBHA, and some by Tribal Health. The coordination between the three isn't as good as it could be. They also felt that there should be more dialogue and involvement of the tribal council.

Families and Staff

The families raised some concerns. They felt there was insufficient communication between the clinical staff and the family regarding the level of treatment. They also felt that the juvenile justice system needs to develop a more caring attitude if they want to be effective. They also raised the issue that some parts of the system maintain confidentiality so strongly that it makes families feel cut-off.

Infrastructure

Clinical Supervisors and Staff

A number of infrastructure issues were raised. Transportation is seen as an issue. The reservation is large, and all the services are centralized. The groups also spoke of a problem with being able to meet basic needs, and the prevalence of unsafe homes.

The group felt that they needed more funding for staff to do things that make a difference but do not generate revenue. These included coordination of services, relationship building and conducting community awareness campaigns. Some felt the need for specialized caseloads, and additional therapeutic modalities to address underlying problems that lead to substance abuse. They specifically mentioned the need for more facilities—including detox and Level 2 and Level 3 facilities.

The professional staff also felt that the caseloads are too high, which impacts the effectiveness of the Child and Family Teams. There was also a comment that staffing in probation, diversion and case management needs to be addressed.

Staff also felt that the community needs an aftercare program, that the children need all-day programming at school and more recreational facilities. They also expressed a desire to have a crisis team.

Families and Adolescents

Families brought up the need for transportation and babysitting. They (and the adolescent group) also mentioned the need for more recreational activities for the youth.

Both professional staff and consumers stated that the system does not do enough for prevention.

The community needs to care more for our children and the elderly.

The RBHA should provide educational liaisons to check on youth in treatment and to provide them support in the program.

Family Group

The Optimal System (Gila River and Pasqua Yaqui)

Many of the thoughts expressed by the groups mirror those of the other regions. Transportation, additional facilities, and a focus on alternative activities and prevention were all mentioned as part of the ideal system. Addressing the infrastructure was important—timeliness, access, training, and staff issues were important. They also stressed the need for a locally based continuum of care—ranging from prevention to residential care to aftercare.

Teach children about our culture and ancestors, i.e. Maze-Walking of Life, Gourd Crafts, etc.

Show children all the jobs and opportunities they could explore.

Family Group

What was unique were some of the specific issues related to Native Americans. The groups clearly wanted a Native American presence in the system—more Native American professionals, indigenous treatment options, and a recognition of the special status of Native American populations. They want to emphasize culturally appropriate treatment options specific to the Yaqui culture.

Several of the participants mentioned art therapy—art tied to their culture. They also emphasized the high level of trauma in the system. The reservations present unique challenges—and the groups felt that those challenges need to be addressed with unique solutions. High on the list is greater involvement of the tribal council, and the need for the tribe to address some of their own issues.

Conclusion and Recommendations

As stated at the onset, there was a tremendous amount of data collected in the various groups. What these data reveal are a number of common issues with adolescent substance abuse treatment, as well as some issues that are region specific. What follows is a discussion of those commonalities and differences, organized along the lines of the regional reports.

Treatment Approaches

Reviewing the regional reports indicates that there are many different treatment approaches used across the state. Among the more common are:

- The Matrix model
- Motivational Interviewing
- Seven Challenges model
- Drug Court
- Cognitive Behavioral therapy.

The groups painted very different pictures regarding Drug Court. For the most part, they considered Drug Court an effective intervention. However, there were some who felt that the implementation was hampered by a lack of cooperation from the probation department and judges.

There were two threads in the groups that stand out. Some in the groups questioned the basis of the “evidence” upon which the practices are based. They also talked about getting more guidance from ADHS on which practices to use with particular problems. There were also statements that questioned the fidelity of the implementation of the practices. Given that there is no standard practice, and the training in various approaches is uncertain, this could be a legitimate concern.

In regard to regional differences, the primary difference was seen in the Tribal RBHAs and the inclusion of traditional/cultural interventions as part of their practice.

In regard to training, there were surprisingly few requests for additional training. This may be a reflection of being comfortable with their current approaches, or a reflection of limited time available for added training.

The families also voiced ideas about treatment approaches. Drug Court was mentioned often—usually in a positive manner. They spoke of

mentoring as a positive practice. But they also voiced a concern about lack of opportunities—not enough residential treatment facilities, not enough counselors, etc.

Treatment Planning and Coordination

Child and Family Team use is widespread, and most agree that they are effective, but only when properly implemented. Clinicians saw the team as an effective way to coordinate treatment, and an effective way to bring the family into the process. They enhance accountability on the part of the whole team.

However, there were concerns. Perhaps the more common general criticism was the lack of cooperation between agencies. Many of the staff, and some families, expressed an opinion that treatment is compromised when the major agencies will not work together. When some parts of the system do not cooperate, the teams do not work. This includes leaving some players out (therapists), or some stakeholders not coming to the meetings (juvenile probation). There was also some concern voiced that the teams' recommendations were not always followed. Therapists, judges, and probation officers often went in other directions.

The concern also includes the parents. The staff viewed some as not wanting to cooperate; others stated that the families do not know how to work with the team. The idea that one staff member made regarding teaching the family how to be part of the team is an intriguing concept.

The families' principal concern was the lack of information—that there were times that they felt like they were not part of the planning, and the team did not necessarily include them. There were clear indications that the families understand the importance of being part of the treatment process, and have a desire to cooperate, but the system did not let them in.

Finally, there was one concern voiced regarding the multiple roles the clinical staff must often take and how those multiple roles could lead to an ethical dilemma. Juggling both clinical and administrative roles could lead to a situation where clinicians recommend a course of action which clashes with their clinical judgment. This could be something to explore in future groups.

Infrastructure

This is the area where most comments were made. Many of the professional groups included the size of the caseload as a problem.

Underlying the caseload issue were insufficient staff, staff turnover, and limited Spanish-speaking staff. Bureaucracy was also mentioned—primarily the paperwork. Nearly everyone complained about the paperwork, feeling it was excessive and did not allow them time to treat the client.

Both professional staff and families cited a general lack of resources to use in treatment. The concerns ranged for a desire for more groups to a need for detox and treatment facilities in some of the more rural areas. Many felt that prevention must be an integral part of the behavioral health process. Parents especially expressed the idea that prevention needs to be addressed in the schools, in the community, basically throughout the system.

The need for after-school, out-of-school activities for the children was also a common concern. The lack of adequate drug-free and safe places for children to go was a point emphasized by parents. Some groups also spoke of the need for safe housing for the young adults who are transitioning from adolescent treatment into the adult treatment system.

Surprisingly, transportation was not just a rural issue. Individuals from all of the regions talked about it, with problems ranging from simple lack of transportation to rules restricting how they can use existing transportation.

For the most part, the infrastructure issues were the same across the regions. However, the Tribal RBHAs did have some unique problems associated with the different service agencies on the reservation and their relationship with the state given they are a sovereign nation.

The Optimal System

This too had common themes that arose in most regions. Primarily, it involves more services, more staff, more options for treatment, lower caseloads, aftercare, and alternative activities for the children. When asked how to transition to the system, the universal solution was more money.

What Can be Done?

Based on the input from the individuals participating in the groups, there are some actions that might be pursued. The following are a list of recommendations that may be considered by the Arizona Department of Health Services.

The Department of Health Services should take the lead in identifying appropriate evidence-based interventions, and insuring that clinical staff throughout the state be given comprehensive training for those interventions.

Many of the providers felt that the DBHS could be more active in providing curricula and training for adolescent-specific treatment approaches. While many different treatment approaches were mentioned, it was unclear the level of expertise and confidence the clinicians and clinical supervisors had in the treatment delivery.

The Department of Health Services should work with the providers to develop approaches to assess treatment fidelity.

Once staff is trained, there is a need to ensure the model is delivered with proper fidelity. The state should work with the providers and model developers to institute a method for assessing fidelity that minimizes the workload while providing meaningful information. Such an assessment could serve as a guide for continuing education for clinical staff.

The Department of Health Services should work with the providers and participating families to develop meaningful outcome indicators.

The true gauge of the efficacy of an intervention is outcomes. The state should work with providers and participating families to develop outcome indicators that reflect achievement of both short and long-term goals for the adolescents and their families.

The Department of Health Services should work with other state agencies to ensure that all appropriate agencies are involved in the Child and Family Teams.

A consistent message across focus groups—professional and consumer—was that the groups work when everyone is on board, and do not when one or more parts of the groups are either not invited or choose not to participate. DBHS may want to consider ways to encourage all agencies to ensure that their staff is willingly involved when appropriate.

The Department of Health Services should ensure that all consumers are educated on the Child and Family Team process, and that the language used to describe the process is understandable to all participants.

A common concern was that families did not fully understand the Child and Family Team process and terminology. The Department should consider developing plain-language literature that describes the process and the families' role in it.

Attachments

Responses to question “What would you say to the Governor about adolescent substance abuse treatment?”

Summary of clinical staff responses about what works, what does not work, and barriers to change.

What would you say to the Governor about adolescent substance abuse treatment?

| Region | What Would You Say to the Governor |
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| NARBHA | <p>Get the inpatient services out of detention Increase the size of the YES program Address all substance abuse, not just Meth Rural and tribal communities have special needs Drug use is multi-generational, and must be addressed at the family level Drug abuse and treatment is not a “sound-bite,” must deal with root causes Must address issues associated with CPS We need money for prevention We need more treatment funding Reduce the state mandates Need more treatment beds Need a community mobilization effort Children need recreational activities, job education The Guidance Center needs money Address cultural and spiritual issues</p> |
| CENPATICO | <p>The area needs prevention education Licensed professionals are not going to stick around with the amount of paperwork and state protocol Increase funding for services and staff Need aftercare services Diversify outpatient services Give the power back to the provider to allow them to exercise their clinical judgment</p> |
| CPSA 3 | <p>More integration of treatment at the state level Spend a day with us—get a better understanding of conditions in the field Train judges on behavioral health Need a better interfacing of behavioral health and justice system Better interface between physical and behavioral health systems National agendas have impacted state and county policies to detriment of border counties (National Guard working on drug reduction moved to patrol border) Meth is going to continue to grow Provide culturally sensitive programs CPS needs to work on effectiveness CPS needs to be part of drug court</p> |

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| <p>CENPATICO</p> | <p>I do not trust the system, the governor did not do what she said she would We need more action on issues, not studies There is a lack of communication Need a client based system, with networked support Do something about the meth issues and teen pregnancy issues in Pinal County Need more money for the rural systems We need money for transportation We need a bus system in Apache Junction—there is no way our clients can get to where the work is. Money—capitation hurts people—there is a real estate boom here, but not adjustments to the caps in the last five years Too much money going to administration, not to direct providers Streamline the paperwork Cenpatico is more consumer focused, but the other was more accommodating Stress the importance of mental health care—many people do not know and fall through the cracks Extend the range of definition kin care—extended families are raising children whose parents are on drugs More aftercare—it will reduce relapse More facilities in rural counties Provide alternative, non-drug oriented activities</p> |
| <p>CPSA 5</p> | <p>Provide more funding, including “one stop shop” for families Provide more ancillary services Provide more bi-lingual services Provide more transportation More flexibility in how to access and use services System is skewed and enforces removal of children and CPS gets much more money Pay line staff more New social workers get the same as new teachers, yet there is always pressure to get teachers more money, but not line staff “If you give more money, you are getting a good investment because it will keep people out of prison later Do not think there are programs for little children and they start really young and develop a serious problem More money for recreational programs More services for people not on meth</p> |

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| | <p>Drug of choice—marijuana, cocaine</p> <p>It's not about what drug they are using, it about why they are using it—cognitive behavioral therapy</p> <p>Parents need to participate in treatment plans more</p> |
| VALUE OPTIONS | <p>The governor should come on site visits to see the real issues</p> <p>Focus on prevention at a young age</p> <p>Put same energy into all day quality childcare that was put into kindergarten—stability at early age will reap benefits later</p> <p>Need to improve interagency collaboration</p> <p>Must address socioeconomic and cultural issues of treatment</p> <p>Focus on proactive solutions</p> <p>System is overloaded</p> <p>Create shared responsibilities across the systems—CPS refers, and leaves the problem to behavioral health</p> <p>Behavioral health has become responsible for families</p> <p>More funding</p> <p>More quality personnel</p> <p>Case loads are too high</p> <p>Do not skip the younger children—start to late and they run out of time to change</p> <p>We are losing the opportunity to help children in school</p> <p>Create community schools and wraparound services</p> <p>AHCCCS is missing the middle families and then people fall through the crack</p> <p>Keep the money—do not give back the block grant</p> <p>More funding</p> <p>Judges need to be more specific about ordering treatment—consider the type, intensity, duration, payer, etc</p> <p>More focus on adolescent substance abuse</p> <p>The governor should spend a day as a clinician</p> <p>I think change needs to happen at the federal level</p> <p>Prevention needs to focus on little children</p> |
| TRBHAs | <p>More money</p> <p>One stop shop that includes family</p> <p>Need a detox facility</p> <p>Need more aftercare support</p> <p>Prevention in junior high and high school</p> <p>Broaden the service area, and the staff to sustain it</p> <p>We need transportation support</p> <p>More native American staff and decision makers (board members)</p> |

**Summary of clinical staff responses about what works,
what does not work, and barriers to change.**

| Region | What's Working | What Needs to Change | What Gets in the Way of Change |
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| NARBHA | <p>(For NARBHA, questioned asked was “Describe the substance abuse treatment program you use?)</p> <p>The YES Program:</p> <ul style="list-style-type: none"> -90 inpatient program located in detention center -12-step based -12 meetings per week -Group and individual -Weekly family group -Community meeting -Referred through probation—failed on probation -Relapse prevention groups for graduates -CFT meeting before entry, at assessment, every 30 days, and at discharge <p>Combining Title XIX funds with Juvenile Probation funding Everyone is doing CFT, and it is going well Good coordination among agencies</p> | <ul style="list-style-type: none"> Need local outpatient group for children not on probation Need to address the family's substance abuse problems No system for getting family's problems addressed Address the disparity between child's willingness to change and parent's willingness Need to address lack of meeting attendance (adolescent and parent) once child is off probation Need to reduce caseloads to help address stress related staff turnover Need to find a way to intensify services in rural areas Need to find funding for non-Title XIX children Need community forum and resources to address at risk children problems early, before caught in the system Need trained workforce Family involvement Work on completion rates— | <ul style="list-style-type: none"> Probation and parole need to work together, especially in regard to aftercare services Staff turnover, both in juvenile probation and behavioral health Transportation must be addressed Lack of staff funding Need to find facility not co-located with detention Funding streams Geographically |

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| | <p>Probation based offsite community services including multi-family, family treatment, and in-home treatment</p> <p>Individual assessment and personalized treatment The inpatient residential unit Multi-level involvement thru the CFT</p> | <p>non-Title XIX children not involved in court do not complete</p> <p>Need to define boundaries with inpatient and outpatient services (agency issue) Transportation due to rural location Requirement that must be AHCCCS eligible, and if under 18, with parents, to use van Paperwork Intake paperwork too extensive Redundant documentation across systems Lack of transitional housing and out of home placements for adolescents—including those turning 18 Underlying family issues, including poverty Staff turnover, limited recruiting ability due to rural location Low motivation to participate Limited in-home services</p> | <p>challenged transportation issues Sufficient workforce Defining and implementing multi-generational treatment process (whole family involved in substance misuse) System seen as detention, not treatment—need reframe</p> <p>State requirements/mandates Funds/money Redundant paperwork Bureaucracy Staff frustration – “We get burnt out asking for the same thing—we just give up.”</p> |
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| CENPATICO | <p>Family and parent involvement— holding them accountable Not treating the child in a vacuum Interagency support—both public</p> | <p>Unrealistic caseload of the clinical liaison Clinical liaisons are expected to do everything—therapist,</p> | <p>Lack of family involvement Bureaucratic mandates— “I wonder if they have</p> |

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| | <p>and non-profit The CFT process—keeps everyone connected Works best in the home—not so good in community or outpatient services location CFT eliminate overlap Proper medication works</p> | <p>supervisor, case manager, team lead, etc. State mandates—like the requirement that everyone has a crisis plan, which is not always appropriate Lack of flexibility in treatment approaches Extremely high caseloads—upwards of 600 and more for Spanish speaking providers Too few bilingual providers Staff retention is difficult Paperwork can be confusing to Hispanics Excessive paperwork -tracked paperwork one week—20 hours -each agency has separate paperwork requirements -half of CFT meeting time is paperwork The state assessment is too long and not comprehensive—we have to add our own questions to find out what we need to Lack of validation for ‘best practices’ – state tells us we have to use it, but do not</p> | <p>experience in direct care service” Disjointed state systems -every level has outdated expectations and have to create their own paperwork -they use terms that our parents can’t understand Workforce retention—licensed professionals do not want to be clinical liaisons Licensure is hurting our profession</p> |
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| | | train, and may not be appropriate for our population | |
| CPSA 3 | <p>Drug court collaboration—specifically parental involvement CFTs-increasing natural links Employment linkages through community support 7 Challenges</p> <p>Drug court when consistent Partnership with drug courts on prevention Youth led coalition ASA helps to understand needs of children Voluntary parental involvement works best—mandated if not voluntary Community involvement</p> | <p>More community partnerships to support children activities Need peer support program Partnerships with school districts, especially for prevention Partnerships with judicial system, including education of judges More residential treatment facilities Intensive outpatient for children not in residential treatment More parental involvement with drug court Parents need to be responsible for changing the environment</p> <p>Need cross-agency structure and consistency Need larger doses of treatment Need more proactive SA adolescent groups Need access for non-court involved children 7 Challenges training for staff other than drug court staff</p> | <p>Unique geographical conditions and culture—the border drug culture Unclear message from law enforcement Criminalization rather than prevention—funding for treatment but no funding for prevention Limitation of funding, facilities, competent personnel Bureaucratic nonsense leads to burnout Reputation of overviewing agency questioned—how SEABHS is viewed in the community</p> <p>Not having a solid agency program that attracts and retains staff Not having a solid program relative to CFTs Different treatment styles across agencies Questions about responsibility—specific to</p> |

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| | | Need treatment models and materials and infrastructure for rural counties/settings | US citizens living in Mexico coming back across the border |
| CENPATICO | <p>7 Challenges, although counselor dependent</p> <p>Family stability helped through case management</p> <p>Increased cross agency collaboration</p> <p>CFTs</p> <ul style="list-style-type: none"> -more of family voice heard -more professional groups involved in treatment, not punishment -family treatment is added to the total picture <p>A prevention alliance works on minors buying liquor issues</p> | <p>Need prevention at early age</p> <p>18 is too late—using, in trouble with law—need prevention early</p> <p>Need more age appropriate counselors and groups</p> <p>Transportation</p> <ul style="list-style-type: none"> -case managers acting as drivers -distrust of system when we say they have to come to treatment or go to jail, then do not provide transportation -can't get to support groups—no bus system <p>Intergenerational family motivation issues—not interested in being involved</p> <p>Need more networking and collaboration</p> <p>Case loads are too high—need more case managers</p> <p>Paper work overload</p> <p>CFT process seems to be on the negative</p> <p>Need more court involvement</p> | <p>Bureaucracy—can't use van unless SMI</p> <p>The penal system—punishes them when they can't go to mandated treatment due to lack of transportation</p> <p>Paperwork</p> <p>High case loads lead to clinical liaison doing case managers work—then do not have time for the child</p> |

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| | <p>Treatment foster home—uses Hazelton model The drug court program The Matrix model ‘Spirit Within’ program Child and Family Team model is how we always do business</p> | <p>Rural areas, very large catchment area and inadequate transportation make it difficult to serve clients Location based treatment model drives additional staff Out of home placement and inpatient services discouraged, even when it is called for Housing is scarce Detox is often deemed not medically necessary Case overload Too much paperwork CPS line staff seems hostile to system Need flex funds, especially for transportation</p> | <p>Funding Wrap-around services took on a life of its own, and chipped away at continuum of care. Care is probation officer dependent Bureaucratic machine—too much paperwork, too much redundancy across agencies Lack of interagency communication</p> |
| <p>CPSA 5</p> | <p>CFTs—really does offer additional support to the child and family not offered in traditional approaches</p> | <p>Across system collaboration -different agencies on the same team may have different mandates -clinician and court may have different ideas than CFT -there are still trust issues on the CFTs There are times when some children get duplicate services (self-paying), and can be</p> | <p>View of provider different from the network Philosophical differences Geographical distances and transportation Client therapist interface—cultural, language differences Family inclusion leads to increased family stress Staff training, experience,</p> |

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| | <p>7 Challenges Harm reduction model, individualized treatment model CFTs—team decision making, no micro management -improved communications with family -clinicians efficacy maximized— not having to do everything</p> | <p>confusing for the child Definition of IOP differs Funding boundaries need not be networking boundaries -just because an agency is not part of the funding stream does not mean they shouldn't be invited to be on the team Interface between judicial and behavioral health needs more attention More residential treatment</p> <p>Placement decisions—sex offenders and substance abusers are difficult to find housing Need more placement options for youth—residential treatment and detention are often the only options Need better communication— especially with probation Staff burnout a continuing problem—high staff turnover, including in CPS Need to find a way to deliver services on their time, not ours -but leads to increasing</p> | <p>availability, retention all affect access</p> <p>Treatment styles differ— need to tweak CFTs to deal with differing opinions Juveniles' definition of success may be different from adult—often a problem with probation Lack of options for juvenile housing Need more money</p> |
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| | | problems with burnout | |
| VALUE OPTIONS | <p>Assessment of SA needs The adolescent IOP program Motivational Interviewing Training for treatment staff Interagency relationships and collaboration CFTs -give the adolescent a voice in treatment -provides in-home services</p> <p>Co-facilitation in groups Small groups 7 Challenges CBT interventions</p> | <p>More availability of services Need more qualified providers—lack of funding main issue More individualized treatment planning—when is enough enough? Creative engagement options Need to look at trauma assessment Transportation Need to address family problems, not treat child in isolation Peer mentoring for parents and adolescents</p> <p>Need a broad philosophical approach to the system of care Need to deal with inter-generational substance abuse solution—substance abusing parents need to be dealt with Maybe make the CFT process legally based like Individualized Educational Plans More intensive treatment for</p> | <p>Not recorded</p> <p>Funding streams—eliminate the gap for 18-24 year-olds Need resources for incentives Bureaucracy—need more flexible, creative, culturally diverse set of linkages to community resources</p> |

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| | <p>Positive interagency relationships Collaboration between providers Individualized case plans and flexibility in services provided Positive working relationship with families</p> | <p>younger substance abusers Need better linkages with community resources, especially for those families not on AHCCCS Need to find supplemental activities for children—ones that do not cost</p> <p>Staff needs additional training on identifying and treating substance abuse problems Need more age appropriate treatment services for adolescents Enrolling adolescents in treatment is difficult and time consuming Relapse needs to be a step in adolescent substance abuse treatment We need a common language</p> | <p>Lack of funding—especially for pilot projects Lack of outpatient SA groups Lack of adolescent inpatient services Difficult to engage families The system is disjointed Need to view adolescent SA as a chronic problem</p> |
| TRBHAs | <p>CFT -Strength based -Culturally appropriate</p> | <p>More care coordinators Need intensive outpatient treatment Need mechanism for child consent when separated from family</p> | <p>Staff—stability, turnover, lack of qualified staff Caseload Money Lack of facilities</p> |

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| | <p>Involving family as a unit because SA is intergenerational Collaboration Having service options</p> <p>State involvement—customer friendly, support, conferences, etc. Team approach—Matrix model, CFT, working as a team with family Tailored services focusing on specific needs of family Building relationships and cultural relevance Access to specialized resources—suicide prevention, respite, addiction specialist Education level of staff—all licensed therapists</p> | <p>Need art therapy Money</p> <p>Probation staffing is insufficient Need aftercare services More collaboration</p> <p>Need to have specialized caseloads More therapeutic modalities that address underlying problems—“We’ve created mini-child prisons where nothing therapeutic is being addressed” More recreational programming More understanding of environment child is being sent back to More dialogue with tribal council Better relationship with court—get involved earlier</p> | <p>Funding Politics Multiple systems serving same need—tribal, RBHA, Feds Community seen as not addressing some issues—sex abuse, domestic violence, SA</p> <p>Lack of funding Lack of understanding of community Not addressing whole family Caseloads too large Ineffective staff mix Need buy in from tribe</p> |
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